No. 98-1284

In the Supreme Court of the United States

OCTOBER TERM, 1998

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

GREGORIA GRIJALVA, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

REPLY BRIEF

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TABLE OF AUTHORITIES

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In *American Manufacturers Mutual Insurance Co.* v. *Sullivan*, 119 S. Ct. 977 (1999), this Court held that (1) private insurers in Pennsylvania's workers' compensation program are not state actors when they deny requests for medical services, *id.* at 985-989, and (2) beneficiaries in that program whose legal entitlement to particular requested benefits has not yet been determined lack a constitutionally protected property interest in those benefits for due process purposes, *id.* at 989-990. Because those holdings have a substantial bearing on the government action and due process issues in this case, a remand in light of *Sullivan* is appropriate. Moreover, because the issues in this case have been radically altered by comprehensive legislation reforming the Medicare practices respondents challenged, the judgments below should be vacated and the case remanded to the district court in any event.

1. This case, like *Sullivan*, turns on whether the decision of an otherwise private actor (an insurer or HMO) to deny a

request for medical services constitutes government action in the context of a comprehensive benefits scheme. Respondents nonetheless argue that a remand in light of *Sullivan* is unnecessary because *Sullivan* "does not modify [the] Court's prior holdings on state action." Br. in Opp. 14. *Sullivan*, however, clarifies the law—"clean[ing] up and rein[ing] in [the Court's] 'state action' precedent[s]," 119 S. Ct. at 991 (Ginsburg, J., concurring in part and concurring in the judgment)—in a way that demonstrates the errors in the lower courts' government-action analysis.

In particular, the courts below concluded that HMO treatment decisions constitute government action because there is a close nexus between HMOs and the government such that HMO decisions may fairly be treated as decisions of the federal government. The courts, however, found that nexus *not* because the government compels or influences HMO decisions, but instead because the "Secretary extensively regulates" HMOs, which must "comply with all federal laws and regulations"; because the Secretary pays HMOs "for each enrolled Medicare beneficiary (regardless of the services provided)"; because the Secretary can "overturn" HMO decisions challenged by the beneficiary; and because the "federal government has created the legal framework * * * within which HMOs" operate. Pet. App. 10a. *Sullivan*, however, holds that "[w]hether such a 'close nexus' exists * * * depends on whether the state 'has exercised coercive power or has provided such significant encouragement, either overt or covert, that the choice must in law be deemed to be that of the State.' " 119 S. Ct. at 986. Because neither court below found, and respondents nowhere argue, that the government exercises such power or provides such encouragement here (see Pet. 17-18 & n.6), the lower courts' rationale does not survive *Sullivan*.[1]

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[1] Respondents attempt to distinguish *Blum* v. *Yaretsky*, 457 U.S. 991, 1004, 1008-1009 (1982), by arguing that this case involves "coverage" decisions rather than medical judgments. Br. in Opp. 18. But they nowhere

Respondents assert that *Sullivan* is "vastly different" because "the state action finding" in this case is "predicated on a comprehensive federal statutory scheme establishing the Medicare program." Br. in Opp. 15. But the benefits scheme at issue in *Sullivan*—workers' compensation—was no less comprehensive or statutory than Medicare. Indeed, in *Sullivan* itself the court of appeals found state action because the private insurers were "providing public benefits which honor State entitlements," "fulfilling a uniquely governmental obligation under an entirely state-created, self-contained public benefit system." *Sullivan* v. *Barnett*, 139 F.3d 158, 168 (3d Cir. 1998).[2]

Alternatively, respondents rely on *West* v. *Atkins*, 487 U.S. 42 (1988). See Br. in Opp. 18-19. The courts below, however, did not rely on *West*, and *Sullivan* expressly rejected reliance on *West*. See 119 S. Ct. at 987-988. Respondents' new-found reliance on *West* thus makes reconsideration in light of *Sullivan* even more appropriate. Besides, *West* is plainly inapposite. In that case, the Court held that the conduct of a prison physician is state action because "the only medical care [the prisoner] could receive for his injury was that provided by the State." 487 U.S. at 55. If the physician "misused his power by demonstrating deliberate indifference to [the prisoner's] serious medical needs," the

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deny that each decision challenged by the named class members in this case is—like the decisions this Court held not to be state action in *Blum*—medical rather than legal in nature. See Pet. 17-18 & n.6.

[2] Likewise, *Sullivan* makes it clear that "extensive[] regulat[ion]," including the requirement that HMOs "comply with all federal laws and regulations," Pet. App. 10a, does not support a finding of government action, 119 S. Ct. at 986, where "the initiative" for the challenged conduct "comes from" the private party "and not from the [government]." *Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345, 357 (1974). And respondents nowhere explain why the fact that the Secretary pays the premium for the Medicare beneficiary to enroll in the HMO, Pet. App. 10a, should make a difference in the government-action inquiry, since the source of that payment neither encourages nor compels HMOs to deny treatment requests. See Pet. 17-18 & n.7.

Court reasoned, "the resultant deprivation was caused, in the sense relevant for state-action inquiry, by the State's exercise of its right to punish [the prisoner] by incarceration and to deny him a venue independent of the State to obtain needed medical care." *Ibid.*

Respondents attempt to bring this case within the reasoning of *West* by arguing that Medicare beneficiaries are "locked in" to and "dependent on" their HMOs for "coverage decisions." Br. in Opp. 19. That argument fails for three reasons. First, the government does not "deny [Medicare beneficiaries] a venue independent of the State to obtain needed medical care," *West*, 487 U.S. at 55; because the Medicare program is not needs-based, Medicare beneficiaries can and do seek medical treatment independent of the program. Indeed, Medicare beneficiaries whose treatment requests are denied not only can obtain treatment from non-HMO providers, but are entitled to have their HMOs pay for that treatment under Medicare if the Secretary determines the denial was improper. See 63 Fed. Reg. 35,108, 35,112 (1998) (adding 42 C.F.R. 422.566(b)(2)-(3), 422.618(a)(2) and (b)). Second, enrollment in an HMO (unlike treatment by a prison physician) is a matter of free choice for Medicare beneficiaries. They can choose among HMOs (where available) or reject HMO coverage altogether by electing fee-for-service coverage. Pet. 17. Third, Medicare beneficiaries may switch among HMOs, or return to traditional fee-for-service Medicare, at any time, effective the end of the month, until the year 2002; after that, they may switch during specified open season periods, or at any time under certain conditions, such as where an HMO fails to provide a required service. See Balanced Budget Act of 1997 (BBA), Pub. L. No. 105-33, § 4001, 111 Stat. 281, 283 (Section 1851(e)(2)(A) and (f)(1), to be codified at 42 U.S.C. 1395w-21(e)(2)(A) and (f)(1)); 63 Fed. Reg. at 35,072-35,073 (adding 42 C.F.R. 422.62(a)(3) and (b)(3)(i)(A)).

Finally, respondents are incorrect to characterize HMOs as "agents" of the government carrying out the "delegated"

function of making benefits determinations. Br. in Opp. 17, 19. Like the insurers in *Sullivan*, HMOs here neither act as government agents in pursuit of a public interest nor distribute public funds. Instead, HMOs responding to treatment requests by Medicare enrollees exercise their own private judgment as to whether they believe the requested treatment is necessary, reasonable, or otherwise within the scope of their obligation to provide—just as the private insurers did in *Sullivan*, and just as HMOs do with respect to enrollees whose premiums are not paid by Medicare. Of course, HMO determinations can be challenged through a dispute resolution mechanism established by the government. See BBA, 111 Stat. 294 (Section 1852(g)(4), to be codified at 42 U.S.C. 1395w-22(g)(4)); 63 Fed. Reg. at 35,111 (adding 42 C.F.R. 422.602(c)). But *Sullivan* makes it clear that the availability of review (an adjudication which "may properly be considered [government] action" and thus subject to due process limits) does not convert the private decision under review into government action as well. 119 S. Ct. at 987. To the contrary, because the initial private decision to grant or deny the beneficiary's request differs little from the decision any private actor confronting potential liability would make, the government's "role in creating, supervising, and setting standards" does not "differ in any meaningful sense from [its role in] the creation and administration of any [other] forum for resolving disputes." *Ibid.*[3]

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[3] Respondents also err in asserting (Br. in Opp. 17) that treating HMOs as private actors would create anomalous distinctions between fee-for-service and HMO-enrolled Medicare beneficiaries. A private physician who refuses to treat a patient on a fee-for-service basis because she believes that the service is not reasonable, necessary, or covered by Medicare surely is not a government actor; respondents have not offered any reason why the result should be different when the same decision is made for the same reasons within an HMO. HMO and fee-for-service Medicare beneficiaries, moreover, are in many ways treated alike. Just as an independent organization acting on behalf of the Secretary makes coverage determinations for fee-for-service treatments, so too such an

2. *Sullivan* also necessitates re-examination of the due process holdings below. In *Sullivan*, this Court held that an applicant for specific medical benefits under Pennsylvania's workers' compensation statute does not have a protected due process interest in those benefits before legal entitlement has been determined. 119 S. Ct. at 990. In particular, the Court explained, the statute there guaranteed payment not for all medical treatments, but rather only for medically necessary or appropriate services. The Court therefore held that beneficiaries under that statute do not have a protected interest in the requested benefits until medical necessity or appropriateness has been determined. *Ibid.* The Medicare statute similarly does not entitle beneficiaries to coverage for all medical treatments; instead, it provides coverage only for services that are, among other things, "reasonable and necessary." 42 U.S.C. 1395y(a)(1)(A).[4]

Of course, the respondents in *Sullivan* did not contend (and the Court therefore did not address) whether the beneficiaries might have a property interest in their claims for benefits, as distinct from the benefits themselves. 119 S. Ct. at 990 n.13. But respondents here likewise have not raised that argument, and neither court below analyzed the due process issue in those terms. An order granting the petition and remanding in light of *Sullivan* therefore is especially

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organization reviews all disputed HMO treatment decisions, and the provisions for further administrative consideration and judicial review of those decisions are similar as well. Compare 63 Fed. Reg. at 35,111 (adding 42 C.F.R. 422.592-422.608) with 42 C.F.R. 405.802-405.817 (1996).

[4] Respondents' claim that federal courts have "long recognized that due process principles apply to the Medicare package of health benefits" (Br. in Opp. 20) is unavailing. The only case from this Court that respondents cite (Br. in Opp. 5, 20), *Schweiker* v. *McClure*, 456 U.S. 188, 198 (1982), nowhere holds that mere applicants for Medicare benefits have a protected property interest in those benefits before legal entitlement is established. And the lower court decisions (Br. in Opp. 6, 9, 17, 20), *Kraemer* v. *Heckler*, 737 F.2d 214 (2d Cir. 1984); *Gray Panthers* v. *Schweiker*, 652 F.2d 146 (D.C. Cir. 1980); and *Martinez* v. *Richardson*, 472 F.2d 1121 (10th Cir. 1973), were decided without benefit of *Sullivan*.

appropriate. See also *id.* at 991 (Breyer, J., concurring in part and concurring in the judgment) (expressing the view that there may be "individual circumstances" under workers' compensation where "receipt of earlier payments" may give rise to a constitutionally protected property interest).[5]

3. The decisions below also should be vacated and the case remanded to the district court for reconsideration in light of the Balanced Budget Act of 1997 (BBA) and the Secretary's implementing regulations, 63 Fed. Reg. at 34,968. As we have explained (Pet. 20-26), those measures comprehensively reform the practices at issue in this case, replacing the prior program with the new Medicare+Choice program.

a. Attempting to minimize the significance of the BBA and the new regulations, respondents argue that they do not substantially alter the current controversy. Br. in Opp. 23. That argument is incorrect. The new Medicare+Choice program and implementing regulations address the very practices that respondents challenged in this lawsuit. They address the primary concern the district court identified by requiring HMOs to ensure that their notices of decision are *understandable*. Compare Pet. App. 46a-50a, 60-61a with Pet. 7, 11, 21 (explaining new provisions). They address the need for faster decisions, requiring HMOs to make decisions

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[5] As explained in the petition (at 18-19), the Ninth Circuit also erred by declining to give "substantial weight" to the Secretary's judgment regarding what procedures are necessary to ensure fundamental fairness in this context, in direct contravention of *Mathews* v. *Eldridge*, 424 U.S. 319, 349 (1976). And it likewise erred in approving a detailed injunction imposing new procedures, rather than remanding to the Secretary so that she could develop appropriate procedures through a fully participatory, public rulemaking. See Pet. 19. Respondents do not attempt to defend the latter aspect of the Ninth Circuit's decision. In attempting to defend the former, they argue (Br. in Opp. 20-21) that the Ninth Circuit did not refuse to give the Secretary's views "substantial weight," but instead declined to accord her views "great deference." Whether or not that is a distinction with a difference, respondents nowhere suggest that the Ninth Circuit accorded the Secretary's judgments *either* "substantial weight," as *Mathews* requires, *or* deference.

within 72 hours for urgently needed services, and within 14 days in ordinary cases; the regulations before the district court, in contrast, had a 60-day deadline and no expedition mechanism for urgent cases. Br. in Opp. 23 (conceding significance of new expedition mechanism); compare Pet. App. 51a-52a, 60a with Pet. 4, 8, 10-11, 21. And the BBA and the new regulations also address a host of related issues, including the qualifications of decisionmakers, pre-termination review for in-patient hospital care, and protection of medical professionals who assist beneficiaries in processing appeals. Pet. App. 49a, 62a; Pet. 8, 11-12, 21 & n.11.

Respondents argue, however, that their challenge is not moot because the new provisions "do not satisfy the requirements of the district court's remedial order." Br. in Opp. 22. But it is not compliance with the district court's order that renders the appeal moot. It is the fact that the BBA and implementing regulations have *replaced* the program respondents challenged and thus have so "altered" the circumstances of the dispute that the case (if it remains a live controversy at all) now "present[s] a substantially different controversy from the one the [courts below] originally decided." *Northeastern Fla. Chapter of the Associated Gen. Contractors* v. *City of Jacksonville*, 508 U.S. 656, 662 n.3 (1993); *id.* at 670-671 (O'Connor, J., dissenting); Pet. App. 66a (district court's recognition that "on appeal much of the March 3, 1997 Order might be moot" because of "efforts on the part of state and federal legislatures [to] address[] the same issues addressed by [the district] [c]ourt").

In fact, respondents' complaints about the new Medicare+ Choice program—that it reduces the time during which HMOs must issue decisions in non-urgent cases from 60 days to 14 days rather than to 5 days, as the district court ordered, and that it requires pre-termination hearings only with respect to in-hospital treatment rather than for all services falling in the vague category of "acute care," Br. in Opp. 23; Pet. 22 n.12—only underscore the changed nature of the dispute. The district court may have concluded that two

months even in non-urgent cases was so excessive as to violate due process, but it has not reached the same conclusion with respect to the two-week period under the new program. Indeed, unless the district court were to conclude that the differences between 14 days and 5 days, and between so-called "acute care" and "in-hospital" treatment, are of constitutional dimension—a dubious proposition respondents nowhere advance—then the BBA and implementing regulations leave no constitutional deficiency to redress.[6]

b. Alternatively, respondents argue (Br. in Opp. 26) that the Secretary may obtain relief from the district court by filing a motion under Federal Rule of Civil Procedure 60(b). This Court, however, has never suggested that a Rule 60(b) motion is an appropriate substitute for vacatur and remand when a new law moots lower court decisions that otherwise warrant this Court's review. To the contrary, the Court's practice has been to vacate the judgment of the court of appeals and remand the case to that court with directions to (1) vacate the district court judgment and (2) remand to the district court for reconsideration in light of the intervening legislation. See Pet. 23 (citing, *inter alia*, *Calhoun* v. *Latimer*, 377 U.S. 263, 264 (1964) (per curiam); *Heckler* v. *Lopez*, 469 U.S. 1082 (1984) (mem.)); see also *United States Dep't of the Treasury* v. *Galioto*, 477 U.S. 556, 559-560 (1986); *United States* v. *Chesapeake & Potomac Tel. Co.*, 516 U.S.

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[6] As explained in the petition (at 23-24 & n.13), the BBA also eliminates the subject matter—risk contracts under 42 U.S.C. 1395mm(g)—on which the district court purported to act, and renders inoperative the statutory language in 42 U.S.C. 1395mm(c)(1), upon which both courts below relied. Respondents dispute that, arguing that those provisions have not been repealed. Whether or not those provisions have been repealed, they have been rendered inoperative with respect to the HMO risk contracts at issue here. The Secretary's authority to enter into such risk contracts under Section 1395mm(g) has been withdrawn; no Section 1395mm(g) risk contracts remain in force; and Section 1395mm(c)(1) has no effect here because it applies to contracts under Section 1395mm(g) but not to contracts under Medicare+Choice. See Pet. 9-10 & n.2.

415, 416 (1996) (per curiam).[7] That course is especially warranted here because the Ninth Circuit's decision resolves important issues of constitutional law for about one-fifth of the nation's populace, profoundly affects an important national program involving hundreds of HMOs and millions of Medicare beneficiaries, and therefore plainly warrants certiorari, especially in light of *Sullivan*.

c. Finally, respondents (Br. in Opp. 26-27) fault the Secretary for not suggesting mootness to the court of appeals. The short answer is that, at the time the case was before the Ninth Circuit panel, the new Medicare+Choice program had not been implemented, and the program and practices that respondents challenged were still in place. Because those circumstances have since changed, vacatur and remand is now appropriate.

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For the foregoing reasons and those stated in the petition, it is respectfully submitted that the petition for a writ of certiorari should be granted, the judgment of the court of appeals vacated, and the case remanded to the court of appeals with directions to (1) vacate the judgment of the district court and (2) remand the case to the district court for further consideration in light of *American Manufacturers Mutual Insurance Co.* v. *Sullivan*, 119 S. Ct. 977 (1999); Sections 4001 and 4002 of the Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 275-330; and the implementing regulations of the Secretary of Health and Human Services.

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[7] *Agostini* v. *Felton*, 521 U.S. 203 (1997) (see Br. in Opp. 26) did not involve, and nowhere discusses, the appropriate disposition of appeals mooted by legislation pending review; it merely discusses the standards for Rule 60(b) motions. *Standard Oil* v. *United States*, 429 U.S. 17 (1976) (per curiam), addresses only the propriety of a Rule 60(b) motion based on new evidence discovered after the judgment was affirmed on appeal.